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Beyond the Scope: The Hidden Images of Eating Disorders

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The complexities of eating disorders have often made them difficult to diagnose and treat. Gastrointestinal symptoms are among the first physical signs and may precede even the patient's awareness of the disorder. Early diagnosis and treatment are critical to success in recovery, making the gastroenterologist's understanding of eating disorders key to the ultimate outcome for the patient. Healthcare seeking, symptom tolerance, and illness behaviors are tied not only to the physical issues presented, but are highly influenced by a variety of psychosocial factors, making it imperative that treatment for these difficult cases is multidisciplinary with an emphasis on the biopsychosocial model.

INTRODUCTION

The gastroenterology practice, perhaps more than any other area of specialization, is complicated by the influence of psychological distress on severity or activity of disease. Even healthy subjects experience symptoms of abdominal discomfort with psychological stress, affecting secretions, motility, pain perception, and vascularity—and in every possible area of the GI tract (1). In today's high-pressured, achievement-focused society, increasing numbers of people turn toward, or away from, foods and food-related behaviors in an effort to mitigate stress for comfort, to gain control, or in efforts to improve self-worth. As Ellyn Satter stated in her essay, *What is Normal Eating?* "Normal eating is giving yourself permission to eat sometimes because you are happy, sad, or bored, or just because it feels good" (2). However, in certain individuals, these emotionally related eating behaviors and attitudes become exaggerated, chronic, and the dominant method of coping and an eating disorder may develop.

Due to the prevalence of GI symptoms in the majority of eating disorder patients, the gastroenterology practice is often the initial medical contact for these clients. It is well recognized that early diagnosis and treatment of

(continued on page 38)

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(continued from page 36)

eating disorders is the key to shorter duration of the disorder, improved symptom control, and better long-term outcomes—including the reduction in morbidity and mortality (3–5). However, the very nature of the disorders complicates even the diagnosis. These patients often present with layers of complexities—medical, nutritional, and, perhaps most complicated, the psychosocial. Furthermore, these patients are also quite difficult to identify due to the patients' inherent tendencies to be secretive, unassertive, and even shameful about their behaviors—even though they may wish for help. Others with eating disorders may be proud and protective of these behaviors and will resist diagnosis and treatment.

Even for those who have been clearly diagnosed, treatment is often difficult. In the past, treatment of eating disorders focused on medical and nutrition issues only, addressing symptoms and restoring nutrients and weight. This biomedical approach produced limited success in long-term recovery, however, and research began to reveal the web of psychosocial variables that also contributes to, and often dominates, these disorders. As treatment programs have become better researched and designed, it has become apparent that a well-experienced, interdisciplinary team approach is essential. The gastroenterologist often plays a crucial role in this treatment model. As the entire gastroenterology team develops expertise in identifying related symptoms and incorporating the biopsychosocial model in treatment and referral, outcomes for these eating disorder patients can be optimized and greatly enhanced.

HIDDEN IMAGE: CASE STUDY 1

Thin, Caucasian, Young Females: Hiding Behind Stereotypes

JD was a 39-year-old fit, professional male who presented to his primary care physician (PCP) with symptoms of intractable vomiting beginning in the middle of the night and lasting several hours. He was referred to gastroenterology for a series of tests, all of which provided no insight into the etiology of his problems. After thousands of dollars of tests, exams, and other evaluations, he returned to his PCP frustrated and was ultimately hospitalized for further evaluation. As his hospitalization progressed and all efforts to explain his condition and symptoms had proven futile, a partner in the PCP's practice suggested that a consult with a dietitian "couldn't hurt." The hospital dietitian began her consult with a casual query and discussion of his "usual day," including what he was doing, eating, and experiencing. His recall was uneventful and inconsequential until he stated that after dinner, around 8 P.M., "my eating disorder begins." She asked whether or not he was kidding or if he truly felt he had a problem. "I KNOW I have a problem; I know I have an eating disorder." He then described in detail his uncontrolled binging, which could last until as late as 3 A.M. when his vomiting would start, and this pattern repeated itself daily. When asked if he had told anyone during his previous medical interventions, his answer was simple: "No one ever asked."

Because of the training that the majority of today's physicians and other healthcare professionals have received, especially those trained before the late 1990's, they may have little experience in the biopsychosocial model and, hence, may not be alert for warning signs indicating possible eating disorders. Even if they are aware, the physician has often been reticent to address psychologically-related health issues, feeling it is out of the scope of practice or that his time is too limited. As a result, statistics indicate that up to 50% of all eating disorders are missed in the physician's practice (5). There is considerable evidence of the opportunities for a circuitous detection of eating disorders by non-mental health clinicians, including gastroenterologists (6), but in one related study, only slightly more than half of the patients volunteered the information on their own (3). However, if the healthcare professional inquired about the possibility, the vast majority (almost 91%) disclosed the information (3). Many eating disorder patients have markedly low self-esteem, perhaps long-term, and are ashamed of their behaviors, and may wish desperately for help in recovery. Yet, this embarrassment and lack of confidence creates a resistance to sharing for fear of negative judgment, lack of trust, and/or resignation to their illness with failure to see hope for recovery.

Historically patients with eating disorders have been stereotyped as patients who are young, female, Caucasian, and excessively thin. A common assumption, spread through media inaccuracies, is also that these clients never feel thin enough. Eating disorder clients

often do feel that sentiment, but a large number of both anorexia nervosa (AN) and bulimia nervosa (BN) patients have a different body image altogether with a distinctly different concern: they feel that their current weight is not the issue at all—that they are actually either too thin or even at an acceptable weight. Their greatest fear is that if they eat *without disordered behaviors*, they will begin an irreversible cycle of uncontrolled weight gain to obesity (personal experience of the author).

The demographics, in fact, are quite complex (7–10). Although at one the time the young female stereotype may have been more accurate, and there continues to be a predominance of patients who fit that generalization, today's eating disorder patients represent all ethnic groups, all socio-economic levels, both male (up to 10% or more) and female genders as well as transsexuals, wide span of age groups, and all nationalities. Failing to recognize the demographic possibilities outside the norm can delay or compromise the diagnosis.

In addition to communication barriers in many of these patients, they may also *hide under the guise of another illness*. Patients with Type 1 diabetes may be at increased risk and will avoid using their insulin as a disordered method of weight loss or avoiding weight gain with binging (the latter being termed "diabulimia" in the popular media). Hypothyroid patients may take excessive amounts of thyroid hormone replacement to enhance metabolism and lead to weight loss. Additionally, recent research indicates that patients with celiac disease may also be at risk of hidden eating disorders, as they use gluten and subsequent malabsorption and diarrhea as a method of weight loss (11–13). In a GI practice, the complications for any of these behaviors may exacerbate themselves with GI symptoms, yet the disordered eating behaviors can be easy to overlook with a dominant pre-existing chronic disease or condition.

Athletes, either competitive or recreational and at any age, with disordered eating behaviors can also be difficult to assess. Many of the symptoms of an eating disorder would be consistent with peak performance: amenorrhea in females, difficulty maintaining weight, focus on body image, emphasis on eating only healthy foods, counting calories to ensure optimal weight is maintained, etc. A popular term has been coined for disordered eating behaviors among athletes: "anorexia athletica or compensatory exercise," but neither of these is a recognized diagnosis. Concern over eating disorders in female athletes led to the definition of the "The Female Athlete Triad" in 1992 by the American College of Sports Medicine. The Triad consists of three interrelated conditions: amenorrhea, osteoporosis, and disordered eating. Intense education efforts are being directed not only to coaches, trainers, and others in the athletic world but to physicians and medical personnel, as well, in hopes of enhancing knowledge and treatment recommendations (14,15).

HIDDEN IMAGE: CASE STUDY 2

The Formal Diagnosis: Hidden in the Details

PN was a mid-20's female doctoral student who presented to the nutritionist's office for a consult in weight management. As the session progressed, she revealed a history of considerable weight gain since entering college, reaching a high of 265 pounds several months previously. With considerable frustration at having had multiple failed trials with commercial weight loss programs in the past, she shared that she began to try to lose on her own, with a goal to reach a weight of 140 pounds, within the normal body mass index (BMI) range. As the consult progressed, the patient began to open up more and began to discuss details of her weight loss. She reported that she restricted foods severely which was initially painful and difficult, but as she lost weight quickly, her motivation to continue escalated, and she felt "energized." Positive comments from her professors and others in her program further fueled her behaviors. She restricted more and more until her calorie intake was less than 500 calories each day, and she began to exercise several hours daily. When she reached 170 pounds, she became concerned that she might have an eating disorder, so she made an appointment to see her PCP, not sharing with the receptionist her reason for the consult. As the physician walked into the exam room, his first statement was, "You are looking GREAT, and I see you've lost about 100 pounds. Congratulations!" She was so surprised and upset that she smiled and thanked him and proceeded to tell him she had come in for just a routine gynecology exam, even though she knew, regardless of the fact that she was still overweight, that she had some form of an eating disorder.

Eating disorders are classified by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision (DMS-IV-TR™) into three categories: anorexia nervosa or AN (307.1), bulimia nervosa or BN (307.51) and eating disorder not otherwise specified or EDNOS (307.50). AN diagnostic criteria are summarized as a refusal to maintain weight at a minimum of 85% of expected; intense fear of gaining weight or becoming fat, even though underweight; body image disturbances; and in postmenarcheal females, amenorrhea for at least three menstrual cycles. AN can be further divided into restricting or binge/purge types. BN diagnostic criteria include recurrent episodes of binge eating; recurrent inappropriate compensatory behaviors to prevent weight gain (e.g. vomiting, laxatives, fasting, excess exercise); binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months; and self-evaluation unduly influenced by body shape and weight. BN is separated into purging and non-purging types. EDNOS is a category representing those eating disorders that do not meet criteria for AN or BN. Examples can include meeting all criteria for AN except amenorrhea, meeting all criteria for AN except weight is normal, meeting all criteria for BN except not binging and purging for three months in a row, etc. (16).

Because the majority of the eating disorders do not meet AN or BN criteria, the appropriateness of these standards has created considerable controversy among experts in the field, especially in light of the fact that the EDNOS category was intended for diagnosing the rare case (9,17–20). Eating disorders can swing from one extreme to another, from BN to AN—and any combination of the two—and assuming a "pure" diagnosis can compromise a full assessment and plan for treatment. As a tragic example, a young woman who was thought to have AN recently experienced a fatal gastric rupture from binge eating, with approximately 5,600 mL of thick fluid found in the abdominal cavity and stomach (21).

At the root of the concerns about the diagnostic criteria is the perception that they are too restrictive and short-sighted and that these criteria evolved from patients seen in treatment centers for their eating disorders—those who may have had the most severe forms. If patients fail to meet the current criteria, they are often denied insurance coverage for treatment, which leads many to worsening behaviors and a heightened resistance to the medical system. Additionally, if professionals perceive the EDNOS patient as not as severely ill, they may not recognize the importance of early referral to treatment, hence delaying recovery and increasing the risk of worsening behaviors and complications. As Dr. Arnold Andersen recently wrote in his article emphasizing the need for a "simpler, clearer approach to diagnosis [of eating disorders]. Asthmatic patients are not told to go home and become more severely asthmatic before they qualify for treatment. Likewise, AN patients do not stop having AN because they exceed 85% of their normal weight, any more than a hypertensive or diabetic patient loses his diagnosis because medical treatment produces normal blood pressure or normal glucose levels." (17).

Frequently, those in the gastroenterology practice may defer formal diagnosis of the eating disorder to the PCP or the psychology professional, and in those cases it may be more useful to focus, not on the exact diagnosis, but on "disordered eating." This term can encompass the wide spectrum of behaviors that may be related to the signs and symptoms and will be crucial to the treatment plan. Additionally, many patients are able to identify with that concept more easily than being labeled AN or BN, and focusing on the bigger picture can be somewhat of a relief to them as they begin work toward recovery.

RECOGNIZING AN EATING DISORDER

Frequently, the key to recognizing the possibility of disordered eating in the gastroenterology patient are not those tiny images seen through the scope, but in the basics—in conversations, whether over the telephone with the front office staff when the patient makes the appointment, speaking with nursing during weigh-ins or while taking vital signs, or even in the conversations with technicians operating diagnostic equipment. Sharing details of their lives in these more casual encounters often feels safer to patients. They may actually be hoping that these staff members will recognize and report these issues in order that they do not need to share these themselves with the physician. Thus, it becomes essential that all office staff and pro-

(continued on page 45)

(continued from page 40)

Table 1
Gastrointestinal Symptoms Associated with Eating Disorders (7–9)

- GE reflux
- Dyspepsia
- Abdominal bloating
- Abdominal cramping
- Constipation
- Diarrhea
- Dysphagia
- Esophagitis
- Anorectal pain disorder
- Atonic or cathartic colon
- Decreased gastric motility
- Delayed gastric emptying
- Irritable bowel syndrome

fessionals are well-trained in recognizing eating disorder signs and symptoms as well as in effective communication skills.

GI symptoms are well-recognized in many practices as clues to disordered eating (Table 1), but other more obvious factors may be overlooked due to lack of staff knowledge or awareness. Risk factors may actually be the first key to an eating disorder and may be revealed far ahead of the actual consult—in the referral information or with patient or family telephone contact. Encouraging staff to be alert to these factors, even in the most atypical patients, is essential (Table 2). Patients may attempt to hide behind many guises in order to prevent recognition, but the obvious physical signs can make this difficult. Staff may easily recognize high-risk patients due to their being underweight but are often less likely to be aware of the other blatant signs (Table 3). Even the signs themselves may be unfamiliar to staff, so it is often helpful to share photographs and other descriptions during training.

HIDDEN IMAGE? OR NOT? CASE STUDY 3

Are You Using Check-Box Evaluations? It May Not Be as Simple as it Seems

EE was a collegiate cross-country female runner who had maintained her usual weight of 125 pounds during the previous two seasons, had competed well and remained healthy. As her junior year began, her coaches noticed that she was gaining weight and competing poorly, so they asked her to come in for regular weigh-ins. She continued to gain weight and when she reached 135 pounds, her coaches referred her to the team sports nutritionist, telling the athlete that they suspected that she had bulimia and was trying to hide it. As the athlete was interviewed, she tearfully expressed frustration again and again at her coaches and denied any disordered eating. In fact, she expressed that she had actually decreased her intake dramatically over the past few months and had still continued her weight gain. During the nutrition assessment, the athlete revealed she had had amenorrhea for the past year, but had attributed that to her heavy training. Upon further questioning in order to rule out possible endocrine-related issues, the athlete indicated that she had had acne which was being treated with medication. She also revealed she was having electrolysis for new facial hair growth and admitted, embarrassingly, that she was plucking her own chest hairs, as

Table 2
Risk Factors that Increase the Probability of Eating Disorders (9,15)

Gender
- More females than males.
- Males have increased risk who are gay, or engaged in a professional position or a sport with weight restrictions

Personality
- AN: perfectionate, sensitive, strong need for approval, persevering, self-critical, black-and-white thinking, immature, dependent
- BN: mood changes, severe self-criticism, impulsive, prioritize others' needs, need for approval from others, black-and-white thinking, worth dependent on weight

Family history
- Depression, obesity, eating disorders

Vulnerable groups
- Dancers, distance runners, swimmers, cyclists, jockeys, gymnasts, models, figure skaters

Critical sensitizing events
- Teasing or criticism about weight, especially by peers, parents, coaches, teachers or others they hold in authority or high regard

Table 3
Visible Physical Signs of Eating Disorders (7–9)

- Weight loss, emaciation
- Petichiae
- Weakness
- Easy bruising
- Abdominal bloating
- Lanugo
- Pallor
- Dry skin
- Slower wound healing
- Dermatitis
- Cheilosis
- Yellow-tinged skin
- Alopecia
- Brittle hair
- Parotid gland swelling
- Knuckle scarring
- Periodontal disease
- Tooth enamel loss

well. She affirmed that she also had a darkening of the skin on the back of her neck (which she hid with her long hair). Recognizing potential insulin- and androgen-related symptoms, the nutritionist referred her to an endocrinologist who ultimately diagnosed her with polycystic ovary syndrome, and after pharmaceutical treatment and additional nutrition counseling, the athlete was able to successfully lose back to her goal weight and resume her level of competitiveness.

The runner above had many of the risk factors associated with eating disorders—her sport, amenorrhea, criticism about weight, and being young and female. It becomes important that, as the staff develops skills in recognizing physical signs, behavioral characteristics, and risk factors for disordered eating, they never become hasty with new stereotyping. In the end, as always, there is no substitute for critical thinking and thorough assessment. In this runner's case, the outcome was quite favorable, but had she not been as resilient and tenacious, the circumstances could have tipped her into an actual disorder or other negative consequences.

Because the GI practice may be an early-stage contact for the patient with disordered eating, effective screening is essential. A number of tools are available for this purpose, some effective and some less so. A "checkbox" approach has been developed by several screen

Table 4
Helping Your Patient to Get to the Truth

- Ask questions as if ANYONE would have these behaviors in the same situation, regardless of how extreme they may appear to you as a professional
- Recognize their statements, but avoid any verbal or non-verbal cues expressing shock or other judgment
- Exaggerate possibilities with your questions
  - "How many BAGS of Oreos is usual for you?" to be followed with, "And then, on a bad day?" and/or "And what else would you eat with those bags?" "And what did you have to drink with that?"
  - "After you ate the jar of peanut butter, what did you eat?"
  - "So your usual purging is 5 times/day. How many might it be on a bad day?"
  - "And when you use laxatives, how many boxes do you use?"

instruments, where the patient is asked a set of closed-ended questions, and if the total meets the questionnaire's criteria, the patient is then evaluated for risk of an eating disorder. These questionnaires can be highly inaccurate for a myriad of reasons. Closed-ended questions may appear judgmental to the client, where they sense that there's a "right" or "wrong" answer. These patients are often highly sensitive to being wrong due to self-esteem or other issues, and they may answer falsely, hoping to elude detection and judgment. Even if the client privately may wish to be diagnosed with an eating disorder, asking closed-ended questions tends to shut many patients down because of the fear and hopelessness they feel as they hear questions related to the behaviors they themselves may loathe. It is critical then that the professionals are well trained in asking questions without judgment, preferably in a relaxed, unhurried manner. Communicating tips are provided in Table 4.

For those professionals with little time for or expertise in comprehensive interviews, quick and simple tools may be a better option. One of the most widely studied instruments for this use is the British-designed "SCOFF Questionnaire" (4,23) (Table 5).

TREATMENT

It is never too early for the diagnostic team to be aware of the goals of recovery because all-too-often profes-

Table 5
The SCOFF Questionnaire

- Do you make yourself Sick because you feel uncomfortably full?
- Do you worry that you have lost Control over how much you eat?
- Have you recently lost more than One stone (equivalent to about 14 pounds)?
- Do you believe yourself to be Fat when others say you are too thin?
- Would you say that Food dominates your life?

sionals equate treatment and recovery with only weight status or cessation of compensatory behaviors. With such short-sighted assumptions, these professionals can actually inadvertently sabotage rehabilitation efforts, as the goals for recovery are actually much more complex (Table 6).

Incorporating these broader goals into the more specific GI treatment goals is essential and is demonstrated in Table 7.

Because of the complexity inherent in these disorders, often predicting a long recovery, the optimal treatment is through an interdisciplinary team that is well-experienced and coordinated. Only rarely is it appropriate and effective for a solo practitioner to handle the entire treatment process. A specialized treatment team generally includes a PCP, a registered dietitian, and a psychotherapist. Optional professional roles are those that are related to specific situations and may include nursing, pediatrics, social work, certified athletic trainers or other professionals. Additionally, because the patient may need continuing or ongoing gastroenterology care, a member from that practice may also be included on the treatment team, helping to ensure seamless treatment and consistency. Each team member's role is designed with specific professional responsibilities, but the team works closely together as well, developing goals for the patient and communicating regularly regarding progress and difficulties to help in refining those goals (8–10,13,22). The psychotherapist is critical to the patient and the team and can provide for professional "supervision," helping other more medically-oriented team members to

Table 6
Goals For Recovery—Participation in a Team Treatment Program

- Acceptance of illness
- Beginning to relax
- Resumption of normal self-control
- Resumption of normal eating
- Diminished fears
- Relief from guilt & depression
- Self-approval (not dependent on weight)
- Achievement of personal goals in a wide range of activities
- New friends
- New interests
- Return of regular menstrual cycles
- Acceptance of personal limitations
- Enjoyment of eating food without guilt
- Appreciation of spiritual values
- Full awareness and at ease with life
- More understanding of family
- Respect of family and friends
- Developing optimism
- Improved self-image
- Increased assertiveness
- Honesty
- Understanding of personal needs
- Trust/openness

advance counseling skills, to provide help with goal setting, and to help handle professional burnout—providing for an optimal biopsychosocial approach. For the physician and staff in a gastroenterology practice, becoming knowledgeable in the risk factors, symptoms, and general profile of an eating disorder can provide important insight into effective GI-specific goal setting as well as an invaluable assessment link to the interdisciplinary team for treatment. Referral in a timely manner is critical, as the cornerstone to recovery is early detection and treatment. This makes it even more critical that the patient's experience in the gastroenterology consult has been positive, open, nonjudgmental, and expressing a genuine concern for helping the patient. It should also include a convincing discussion with the patient and family, as appropriate, regarding the importance of a team treatment program. Otherwise, even though a possible need has been revealed, the patient and/or family may resist and refuse any further evaluation. For those who do refuse further referral, but agree to continue GI treatment,

Table 7
Examples of Recovery-focused GI Goals

Goal for Recovery	*Incorporating with GI goals*
Self-approval not dependent on weight	Providing blind weights and encouragement for non-weight-related progress such as keeping appointments and symptom improvement related to compliance with medications
Acceptance of personal limitations and increased assertiveness	Including the patient in the goal setting
Understanding of personal needs	Encourage regular meal times, along with a prokinetic agent, while keeping a diary of symptoms to demonstrate improvement
Resumption of normal eating	Avoiding goals related to "perfect" eating such as exact calories, grams of fat, exact servings sizes, no binges, etc with a broader emphasis on food's positive role in improving symptoms such as lack of energy, apathy and depression

continuing efforts should be made at subsequent visits to monitor weights, evaluate intake and physical condition, and to use these as tools to help the patient and family see the need for comprehensive treatment (13).

HIDDEN IMAGE: CASE STUDY 4

LT was a nine-year-old male who had completed workups with gastroenterology, neurology, and speech therapy for his unplanned weight loss over the past year, losing from an overweight 160 pounds to his current 130 pounds (still approximately 40 pounds overweight) due to development of stated "digestive problems," difficulty swallowing and related inability to tolerate foods. When the medical specialists were unable to reveal an organic cause, the child and his mother were referred by his Medicaid caseworker to a dietitian for assessment and medical nutrition therapy. The nutrition interview revealed that two years previous, the child had been teased continually in his school about his weight to the point that his mother withdrew him from school and began home-schooling. Due to her need to go back to work following a divorce during that same year, she would often send the child with his father to his work with him. The child was continually berated about his weight and his food choices by his father during these times, yet the child felt intimidated to share what was transpiring until his rapid weight loss became apparent. The greater the pressure with the family issues and his father's criticism, the more the child isolated himself and refused to eat, leading to steady weight loss. The mother, in desperation, began to offer her child anything he would request, and he soon chose to refuse all but ice cream and pudding and other smooth sweet foods, telling her that was all he could swallow and leading her to assume he had developed some form of dysphagia. Recognizing the possible beginning of psychologically-related disordered eating, which had manifested itself in actual/reported physical issues, the nutritionist then recommended a comprehensive psychological evaluation. However, due to the fact that Medicaid and other government resources did not cover such consults, the family did not follow through with the recommendation, and also did not return for nutrition follow-up, lost in the complexities of confusing and uncertain diagnoses, psycho-social-economic difficulties, and an inadequate system.

Even with the best professional teams available, access to treatment is often compromised, especially with the advent of managed care. Some health maintenance organizations may exclude any eating disorder other than those meeting the highly restricted criteria of AN and BN (i.e. excluding EDNOS which accounts for the majority of those diagnosed) or they may exclude eating disorders altogether. Additionally, even though a seriously disordered patient may be more optimally treated as an in-patient, some treatment plans require a trial of outpatient management first (9). Many insurance benefits cover only limited visits and some do not include nutrition or mental health benefits whatsoever. Because many of these patients are young and may either be unemployed (often actually *due to*

(continued on page 51)

(continued from page 48)

their eating disorder) or working without benefits, comprehensive treatment may not even be an option. For eating disordered clients who often lack insight into their disease and may already be compromised in assertiveness and self-worth, feeling isolated and hopeless, dealing with the complexity of insurance regulations and payment issues may be, in the end, the final seemingly insurmountable, barrier to treatment.

HIDDEN IMAGE: CASE STUDY 5

Positive Ending and New Beginnings: The Importance of Hope

MA was a 29-year-old medical intern, just finishing her first year at an elite medical center. She had been participating in multiple sessions daily of evening exercise classes, and her instructor began to question her as he noticed she seemed to be steadily reducing weight and was now appearing to be in a dangerous range. The intern confided in him that she was, in fact, aware that she might have anorexia nervosa but was afraid to mention it to her physician because she feared it might have negative consequences with her eligibility as an intern and ultimately with her career. She was isolated except for attending classes and was still living at home. Her parents had emphasized to her the importance of handling "these things" at home and not to share them with others, especially psychologists who "don't know what they're doing." Her father, in fact, praised her for her weight loss and gave her additional money for clothes as she grew thinner and thinner. The instructor suggested a consult with the club dietitian, and as the student reached out to the specialist, she was ultimately connected to a team of professionals, including the dietitian, a psychologist and a PCP with eating disorder expertise. The intern was, in fact, suspended from her internship for several months in order to dedicate herself to treatment as she successfully gained back to a healthy weight and completed her multidisciplinary outpatient treatment program. She was subsequently readmitted to her internship and successfully graduated. Recognizing her own struggles and how a multidisciplinary approach had so greatly benefited her, even with her sophisticated medical background, she is now in her family practice residency with a goal after graduation of developing and directing a similar team in her own community.

Table 8
Eating Disorders Resources

Academy for Eating Disorders
Resource for specialist practitioners
www.aedweb.org

American Psychiatric Association (APA)
1000 Wilson Blvd., Suite 1825
Arlington, VA 22209
www.HealthyMinds.org

Body Wise
Sponsored by the U.S. Dept of Health and Human Services
www.girlpower.gov/girlarea/bodywise

Eating Disorder Referral and Information Center
www.edreferral.com

Gurze Books
P.O. Box 2238
Carlsbad, Ca 92018
www.gurze.com

National Association of Anorexia Nervosa and Associated Disorders
P.O. Box 7
Highland Park, IL 60035
www.anad.org

National Eating Disorders Association
603 Stewart St., Suite 803
Seattle, WA 98101
www.nationaleatingdisorders.org

Renfrew Center Foundation for Eating Disorders
www.renfrew.org

The common sentiment among almost all untreated eating disorder patients is that they will always have these problems. Once in treatment, they almost universally choose "resumption of normal eating" as their first and primary goal, yet they feel, in their case, that it will likely never happen. They repeatedly report that they are tired of the way the disorder has stolen their lives and become their central focus, yet they don't know how to reverse it. Sadness is pervasive. When others are negative with them and tell them to "just get over it," they can further bury themselves in isolation and feelings of futility. Professionals who are overly sympathetic, rather than empathetic, can unknowingly add to

these already prevalent signs of depression, anxiety and hopelessness. A *critical* part of intervention and treatment then, on the part of professionals, is to provide hope and enthusiasm for the patient's recovery—and to help patients to find that in themselves as well. Working with the patient to establish regular, achievable goals related to the recovery indicators is imperative, as is objective feedback and consistent support, even for the smallest of positive changes. Because these patients are typically goal-oriented and tend to perfection thinking, this feedback can help them to visualize progress and an appreciation of the process of backing out of old behaviors into new. This provides these patients with much-needed confidence, enthusiasm, and hope for recovery. Furthermore, the staff can provide invaluable mentoring benefits for the patient with a positive *realistic* approach, healthy balanced attitudes about their own weight and eating habits, an ability to accept setbacks as only temporary and a part of the process, a friendly open atmosphere, and a sense of their own joy and optimism.

CONCLUSION

As our world becomes more and more complex, ability to adapt will be become critical. Without appropriate coping skills, individuals will continue to be at risk of expressing stress through physical symptoms, disease, and disordered behaviors. With eating disordered patients, avoiding judgment, criticism and blame will be imperative in every medical practice. The development of an eating disorder, after all, springs from very human needs to feel accepted, to deal with distressed moods, to deal with crisis, and to accept oneself (9). The gastroenterology team with a biopsychosocial approach may be particularly well-positioned to provide a marked difference in outcomes, not only for eating disorders but as a holistic approach to diseases and disorders in general. As Dr. John Clark related in his 2007 *JAMA* eating disorders book review, "Most of our body systems function automatically in synchronized harmony, but our digestive system, to the contrary, is subject to the whims of our self-image" (24). As the gastroenterology and other medical teams begin to develop skills at assessing and treating the whole person, moving beyond the more limited biomedical model of pathophysiology and pharmacology, true excellence in the clinical course and outcomes of eating disorders will be possible. ■

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